has not occurred previously, a patient should be encouraged to present within 24 to 48 hours of the onset of symptoms, when cultures are most likely to document the infection. Reliable tissue culture results may be obtained within five days and within 48 hours if immunoperoxidase staining is available. The findings of several clinical studies suggest that vaginal delivery may be done in about 70% of patients at high risk for harboring herpes infection who are followed in this manner. No cases of neonatal herpes have been reported in these studies.

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Vaginal Versus Cesarean Delivery for Breech Presentation

THE TREND TOWARD more vaginal births in cases of breech presentation is based on recent prospective and retrospective reports indicating that in selected, carefully evaluated and monitored women, vaginal delivery carries an acceptable perinatal mortality and morbidity when corrected for congenital abnormalities and prematurity. The major morbid events related to breech labor and delivery are umbilical cord prolapse, head entrapment, cervical spine injury, traumatic delivery or extraction and the occurrence of a nuchal arm or arms. Umbilical cord prolapse occurs in less than 2% of frank breech presentations, but the risk increases progressively from complete to double footling, and is highest in the single-footling presentation. Some investigators have reported that a great proportion of the cord prolapses occur in the second stage of labor. Head entrapment is most frequently encountered in a premature breech, usually when the fetus weighs less than 1,500 grams. Because of inherent errors in estimating fetal weights, a 2,000-gram cutoff would provide a good margin of safety. Cervical spine injuries are associated with an extended fetal head and excessively forceful delivery. There is general agreement that a cervical spine-mandibular angle of 90 degrees or less is *not* extended. Traumatic deliveries or extractions are usually related to overzealous efforts for a vaginal delivery in a patient who has a less-than-totally adequate pelvis, or with labor abnormalities requiring oxytocin augmentation. Brachial plexus injury may result from the management of nuchal arms; the frequency of nuchal arms seems to be increased in the hands of less-experienced operators and when the assisted breech delivery is rushed.

The following guidelines offer a reasonable approach to selecting women with breech presentation for vaginal delivery:

- Gestational age between 36 and 42 weeks.
- Estimated fetal weight between 2,000 and 4,000 grams.
- Clinically adequate pelvis confirmed by x-ray pelvimetry.
- Fetal head not hyperextended.
- Availability and use of continuous fetal monitoring equipment.
- Normal progress of labor.
- Awareness of the risk of a prolapsed cord by the entire medical team.
- An obstetrician who is experienced in vaginal breech delivery.
- The capability to do a rapid cesarean delivery exists during the entire course of labor.
- An anesthesiologist is in attendance.

As in all medical practice, management decisions are based on an assessment of the risks and benefits of a proposed procedure or treatment. We have emphasized the perinatal risks of vaginal breech delivery, but must not ignore the increased maternal morbidity and mortality associated with cesarean birth.

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Abnormal Findings on Papanicolaou Smear: Significance and Management

THERE IS overwhelming evidence accumulating that both the incidence of and mortality from cervical cancer are reduced by screening and treatment of the precursor lesions. Richart showed that squamous cell carcinoma of the cervix begins at the squamocolumnar junction of the transformation zone as a unifocal lesion that is generally well differentiated. The term "dysplasia" has been applied to this lesion. Depending on the degree of dedifferentiation of the cytoplasm of the dysplastic cells, the lesions are described as "mild, moderate or severe dysplasia." As the lesions enlarge, the cells become less differentiated, occupy a larger area of the transformation zone and may grow towards and into the endocervical canal. The end stages of the intraepithelial lesion are generally referred to as "carcinoma in situ." Richart prefers to call these lesions "cervical intraepithelial neoplasia, grades I, II or III" because he considers them continua of the same disease.

Papanicolaou originally reported his cytologic results as class I through V, but with the passage of time the different classes have acquired different interpretations. Cytopathologists are now reporting their results using narrative terms such as "mild, moderate or severe dysplasia and carcinoma in situ" or "cervical intraepithelial neoplasia grades I, II and III," and include other normal and abnormal findings, such as endo-